Report

of the

Examination of

Prevea Health Insurance Plan, Inc.

Green Bay, Wisconsin

As of December 31, 1998

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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November 9, 1999

Honorable Connie L. O'Connell
Commissioner of Insurance
State of Wisconsin
121 East Wilson Street
Madison, Wisconsin 53702

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

PREVEA HEALTH INSURANCE PLAN, INC.
Green Bay, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The current examination of Prevea Health Insurance Plan, Inc. (Prevea or the HMO), covered the period from its inception through December 31, 1998, and included a review of such 1999 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements
Accounts and Records
Data Processing
Enrollee Complaint Procedure
Underwriting

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Prevea can be described as a for-profit, group model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under chs. 185, 611, 613, or 614, or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the group model, the HMO contracts with a sponsoring clinic and/or hospital to provide primary and specialist services. HMOs compete with traditional fee-for-service health care delivery.

The HMO was incorporated on October 23, 1996, and received its license on November 29, 1996. Prevea began operations during 1997, and in 1998 completed its first full year of operations. The HMO is two-thirds owned by Prevea Health Services, Inc. (PHSI), and one-third owned by Wausau Service Corporation (WSC). Employers Insurance of Wausau (EIW), an affiliate of WSC, provides administrative serves for the HMO, as is further discussed in the Management and Control section of this report.

The HMO contracts with 157 primary care and 512 specialty care providers. Prevea Clinic, owned by PHSI, accounts for the majority of the HMO's primary care providers. Referrals must be preauthorized by an enrollee's primary care provider, except for routine eye exams, dental care for wisdom teeth, chiropractic care, and behavioral health care.

The main provider agreement for Prevea is that with PHSI. PHSI, in turn, has contracts with Prevea Clinic and the two hospitals, St. Mary's and St. Vincent, which have an ownership interest in PHSI. The provisions outlined on the next page are the basis of the agreement.

Effective date: The original contract was signed in 1996, with an amendment being executed on January 29, 1999.

Services: PHSI agrees to arrange for the provision of medical services to members, of the same scope customarily provided to members of the public. Prevea and PHSI shall cooperate to establish guidelines for contract negotiations with payors, benefit plans, and providers.

The contract includes an insolvency provision, under which PHSI agrees to continue to arrange for the provision of or pay for the medical services rendered to members prior to the insolvency of Prevea. Under the hold-harmless clause of the agreement, PHSI agrees not to bill members for services, other than for copayments, deductibles, and noncovered services.

Term: Initial term through December 31, 2001; automatically renewing for additional one-year terms.

Termination: (a) By either party giving 180 days' advance written notice prior to the end of a term.

(b) For cause, immediately upon written notice, should a party continue in default of its responsibilities for 30 days after notice of default is received.

Compensation: Base capitation
Compensation is based on a schedule of per-member-per-month capitation rates for the Physician, Hospital, and General funds.

The monthly physician capitation amount is understood to include certain amounts representing services provided on a fee-for-service basis (FFS) by other providers. Prevea, on behalf of PHSI, will pay the participating providers receiving FFS payments. The next month's capitation will be adjusted (reduced) by Prevea for the amount of FFS payments and an amount equal to 60% of the change in IBNR FFS reserves for the month.

Risk-sharing arrangement
Under this arrangement, PHSI pays Prevea a risk charge of $1.00 PMPM, which is deducted from the capitation otherwise payable. For each fund, a surplus or deficit is determined by subtracting the fee schedule or per diem rate amounts for services provided during the year (plus an allowance for incurred-but-not-reported claims amounts) from the actual capitation payments made in the year. The calculated surplus or deficit is further adjusted by a calculation for large claims.

By no later than July 31 of each year, Prevea is obligated to report its calculations to PHSI. Within 30 days, Prevea will pay the amount of any net surplus to PHSI or PHSI will pay Prevea for a net deficit. PHSI will, in turn, bill or pay one-half of the amount to Prevea Clinic and one-half jointly to the hospitals.

Prevea also contracts with other providers for the provision of primary and specialty care. The contracts generally have a one-year term and automatically renew for additional one-year terms. The contracts include hold-harmless provisions for the protection of policyholders. Typically, contracts may be terminated by either party giving 60 days' written notice prior to the end of a contract term. Some contracts require 90 days' notice. The majority of providers are compensated based on the HMO's standard fee schedule, while some are paid on a discounted fee-for-service basis. Beginning in 2000, the

provider contracts are scheduled to include a 20% withhold arrangement. Currently, only behavioral health providers have been subject to such an arrangement.

The HMO contracts with nine hospitals to provide inpatient services, as listed below. Hospitals are reimbursed on a capitation, negotiated per diem, or discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders.

Contracting hospitals are:

Bay Area Medical Center, Marinette
Bellin Hospital, Green Bay
Community Memorial Hospital, Oconto Falls
Door County Memorial Hospital, Sturgeon Bay
Holy Family Memorial Medical Center, Manitowoc
Oconto Memorial Hospital, Oconto
St. Mary's Hospital Medical Center, Green Bay
St. Mary's Kewaunee Memorial Hospital, Kewaunee
St. Vincent Hospital, Green Bay

According to its business plan, the HMO's service area is comprised of the following counties:

Brown, Door, Kewaunee, Manitowoc, Marinette, Oconto, and Shawano.

The HMO offers comprehensive health care coverage that may be changed by riders to include deductibles and copayments. The following health care coverages are provided:

Physician services
Prescription drugs—copayment level varies by type
(generic, brand formulary, non-formulary)
Preventive health services
Routine eye examinations
Routine hearing examinations
Inpatient services
Outpatient services
Emergency care
Chiropractic services
Mental health, drug, and alcohol abuse services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Diabetes treatment
Convalescent nursing home service
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Hospice care
Kidney disease treatment
Certain transplants

Inpatient mental health and AODA coverage is limited to 10 days, transitional care is limited to 20 days, and outpatient mental health and AODA coverage is limited to 30 visits per year. Skilled nursing care is limited to 60 days. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. Members are required to choose a primary care physician from the listing of participating physicians available. The HMO also offers point-of-service (POS) plans, under which a member may choose to seek services from nonparticipating providers, for higher co-payments and lesser levels of coverage. The POS product is jointly underwritten and marketed under an agreement with EIW.

The HMO currently markets principally to groups. Prevea also markets an individual 65+ Medicare supplement product. The HMO uses a mixed distribution force consisting of selected agencies in the Fox Valley area and direct sales staff employed by EIW.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted for age/gender distribution, benefit plan, area, trend, and administrative cost on a group-by-group basis. Experience is reviewed for renewal groups; credibility factors are used to blend the “book” rate with the experience rate, giving more weight to the experience portion of the rate as the group size increases. Small groups are handled separately, using a rate tier system to recognize medical risk factors within the requirements set forth by the state.

The HMO has developed procedures to monitor the actions of its primary care physicians. The Medical Care Facilitation program is carried out under the oversight of the medical director. The program, outlined in each provider’s contract, includes peer review, physician credentialing, hospital stay certification, quality assurance, and utilization review activities. Committees participating in the activities include medical care facilitation, credentialing, quality assurance, and utilization management.

Prevea has in place a grievance procedure pursuant to s. Ins 3.50 (10), Wis. Adm. Code. The grievance procedure is explained in the plan member’s certificate of coverage.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nine members. Per the articles of incorporation, directors are to be elected to staggered three-year terms. Six directors are elected by the holders of Class A common stock (PHSI) and three are elected by Class B (WSC). See further discussion of directors' terms in the section of this report captioned "Summary of Current Examination Findings." Officers are appointed by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding company group. The board members currently receive no additional compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
James G. Coller De Pere, WI	Administrator, St. Mary's Hospital	#
G. Robert Kaftan, MD De Pere, WI	President/CEO, Prevea Health Services, Inc.	#
John Laehn Wausau, WI	Vice President—HMO Operations, Wausau Insurance Companies	#
Gary D. Leach Springfield, IL	Vice President—Fiscal & Corporate Services, Hospital Sisters Health System	#
Ronald Menaker Green Bay, WI	Executive Vice President, Prevea Health Services, Inc.	#
Nick Mischler, MD Schofield, WI	Medical Director, Prevea Health Insurance Plan	#
Fred Moore Wausau, WI	Senior Vice President—Benefits, Wausau Insurance Companies	#
Paul E. Reckard, MD De Pere, WI	Past President, Prevea Clinic	#
James A. Temp Green Bay, WI	Chairman, Aon Risk Services of Wisconsin, Inc.	#

- Current definition of director's term: the individual "shall serve until his successor shall have been elected or until his prior death, resignation, or removal."

Officers of the Company

The officers elected or appointed by the board of directors and serving at the time of this examination are as listed below:

Name	Office	Compensation
Mark Minsloff	President/CEO (effective 9/30/99)	$104,583*
Paul Reckard, MD	Chairman of the Board	*
Frank Robinson	Treasurer (effective 3/25/99)	*
Ronald Menaker	Secretary	*

* - Note: Other than the President/CEO, officers are salaried employes of other companies affiliated with Prevea, and do not receive any additional direct compensation for serving as officers of the HMO. The salary listed above was paid to Mr. Minsloff's predecessor during 1998.

Committees of the Board

The HMO's bylaws allow for the formation of certain committees by the board of directors. At the time of the examination, the HMO had an executive committee as listed below:

Executive Committee
Paul Reckard, MD, Chair
James Coller
John Laehn
Ronald Menaker
G. Robert Kaftan, MD
Mark Minsloff, ex-officio

In addition, Prevea has the following management committees, which report to the board:

Credentialing Committee
Finance Committee
Focused Management (Operating) Committee
Grievance Committee
Medical Care Facilitation Committee
P&T Committee
Practitioner Advisory Committee
Quality Assurance Committee
Marketing Committee
Utilization Management Committee

The HMO has no employes. While the board of directors remains ultimately responsible for the operations of the HMO, necessary staff is provided through an administrative services agreement with EMPLOYERS INSURANCE OF WAUSAU, A Mutual Company (EIW). Under the agreement, effective January 1, 1997, EIW's duties include marketing, underwriting, contract issuance, premium billing and collection, claims administration, actuarial services, maintenance of accounting and other records, and provision of data systems. EIW's administration fee is based on a per-member-per-month amount. The contract establishes a number of performance standards for EIW. For each standard not met, EIW is required to give Prevea a credit of 0.25% of the fee for the period, up to an aggregate annual maximum

credit of 5%. The initial term of the agreement is through December 31, 2001, automatically renewing for additional three-year terms thereafter, unless otherwise terminated. The agreement may be terminated under the following circumstances: by OCI, with 30 days' written notice, to protect the interest of Prevea's members, enrollees, or creditors, or the public; automatically should Prevea not be able to legally continue operations; automatically upon bankruptcy of either party; upon 10 days' written notice by either party if default of an obligation continues without good-faith efforts to cure such default.

Financial Requirements

The financial requirements for an HMO under s. Ins 3.50, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 Or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million Or 110% of compulsory surplus
4.	Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;
2. One-third of 1% of premium written in this state in the preceding calendar year.

The HMO has satisfied this requirement for 1998 with a deposit of $150,000 with the State Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 3.50, Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

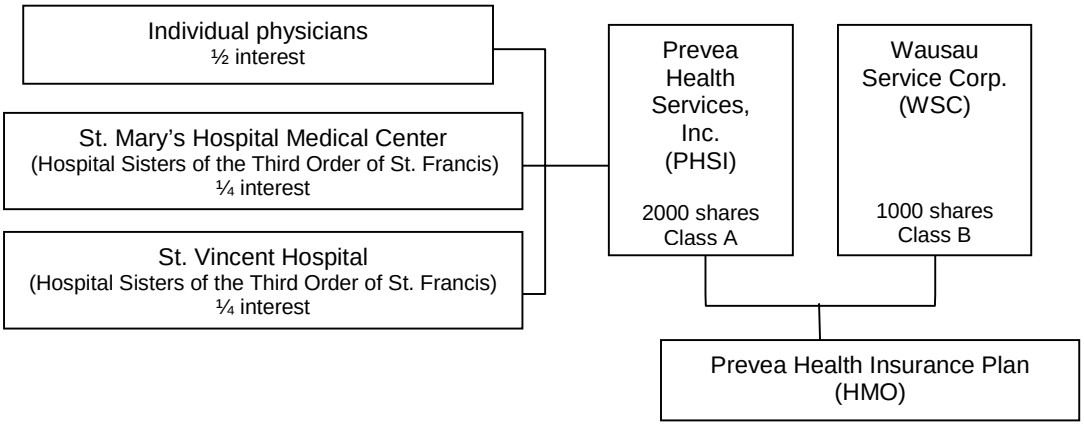
1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.

For 1998, the HMO has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report. However, in 1999, the HMO's reinsurance agreement does not contain these provisions. See further discussion in the section of this report captioned "Summary of Current Examination Results."

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. A controlling interest in Prevea's common stock is owned by PHSI. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Holding Company Chart
As of December 31, 1998



Prevea Health Services, Inc.

Prevea Health Services, Inc. (PHSI), is a holding company. In addition to owning a majority interest in the HMO, PHSI owns Prevea Clinic and Prevea Regional Services, Inc. As of December 31, 1998, the company's audited consolidated financial statements reported assets of $49,733,535, liabilities of $20,198,697, and stockholders' equity of $29,534,838. Operations for 1998 produced a net loss of $(4,226,897) on revenues of $78,813,350.[1]

[1] The net losses experienced by Prevea Health Services, Inc., were anticipated by management in connection with the formation and growth of this new organization. Prevea Health Services, Inc., was formed in 1996.

Wausau Service Corporation

Wausau Service Corporation (WSC) acts as a holding company for property and casualty insurers and non-insurance companies. As of December 31, 1998, the company's audited financial statement reported assets (in thousands) of $184,873, liabilities of $14,769, and stockholders' equity of $170,104.

The administrative services agreement between Prevea and EIW, a WSC affiliate, is discussed above in the Management and Control section of this report.

V. REINSURANCE AND CORPORATE INSURANCE

The HMO had reinsurance coverage for 1998 under the contract outlined below:

Reinsurer:	EMPLOYERS INSURANCE OF WAUSAU A Mutual Company
Type:	Stop Loss Insurance
Effective date:	January 1, 1998
Retention:	$100,000
Eligible Expenses:	Coverage A: 80% of amount of claims that exceed $25,000 less an amount equal to $1.76 times the total number of months that all enrollees are covered under a contract during the plan year.
	Coverage B: 80% of amount of claims that exceed $75,000 less an amount equal to $2.44 times the total number of months that all enrollees are covered under a contract during the plan year.
Coverage:	Coverage A: Physician services provided by PHSI
	Coverage B: Hospital services provided by PHSI
	Coverage C: Coverage provided by Prevea other than for services provided by PHSI under Coverage A and Coverage B.
	Aggregate Stop Loss: In the event the eligible expenses for Coverage A, B, and C exceed in any one year the deductible amount specified on the declarations page, EMPLOYERS INSURANCE OF WAUSAU will pay on behalf of Prevea such excess expenses.
Premium:	$0.45 PMPM
Termination:	By the reinsurer giving not less than 10 days' written notice for nonpayment of premium, or material misrepresentation, or substantial change in the risk assumed, or substantial breaches of contractual duties.

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. EMPLOYERS INSURANCE OF WAUSAU will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge and after all other sources of funds have been exhausted.

2. EMPLOYERS INSURANCE OF WAUSAU will make available to all members without evidence of insurability, a replacement coverage of the same benefit schedule and rates as then being offered by EMPLOYERS INSURANCE OF WAUSAU to other prospective insureds within the state.

The HMO entered into a new reinsurance contract for 1999. At the time of examination fieldwork, the contract was still being finalized. The HMO provided a binder for coverage, which outlined the following terms of the reinsurance contract:

Reinsurer:	Employers Reinsurance Corporation
Effective date:	January 1, 1999
Retention:	$100,000 (except $150,000 for four specified members)
Coverage:	Commercial and In-network Point-of-Service
Coinsurance:	90%
Premium:	$1.31 PMPM

The binder specifically excludes conversion and insolvency coverage. See further discussion in the section of this report captioned “Summary of Current Examination Results.”

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	**Policy Limits**
Commercial general liability	
General aggregate limit	$2,000,000
Each occurrence	1,000,000
Products/completed operations	1,000,000
Personal & advertising injury	1,000,000
Fire damage (any one fire)	50,000
Medical expense (any one person)	5,000
Worker’s compensation and employers’ liability	
Each accident	100,000
Disease (policy limit)	500,000
Disease (each employe)	100,000
Managed care organization errors & omissions liability	4,000,000

The above coverages were obtained through insurers that are licensed in Wisconsin or on the Commissioner's current list of approved surplus lines insurers.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 1998, annual statement to the Commissioner of Insurance. Adjustments made as a result of the examination are noted in the section of this report captioned "Reconciliation of Net Worth per Examination." Also included in this section are schedules that reflect the growth of the HMO for the period under examination.

Prevea Health Insurance Plan, Inc.
Balance Sheet
As of December 31, 1998

Current Assets:			
Cash and short-term Investments		$2,386,882	
Premiums receivable—net		499,926	
Amounts due from affiliates		378,997	
Reinsurance recoverable on paid losses		896,850	
Aggregate write-ins for other current assets			
—ASO receivable		7,467	
Total current assets			$4,170,122
Total Assets			$4,170,122
Current Liabilities:			
Claims payable (reported and unreported)		$1,189,101	
Unearned premiums		419,610	
Amounts due to affiliates		678,123	
Aggregate write-ins for other current liabilities			
—Funds held by company	599,994		
—Loss expense reserve	58,400		
—Misc. payables	67,597		
		725,991	
Total current liabilities			3,012,825
Total Liabilities			3,012,825
Net Worth:			
Common stock		3,000	
Paid-in surplus		1,497,000	
Retained earnings/fund balance		(342,703)	
Total net worth			1,157,297
Total Liabilities and Net Worth			$4,170,122

Prevea Health Insurance Plan, Inc.
Statement of Revenue and Expenses
For the Year 1998

Revenues		
Premium	$30,892,822	
Investment	47,601	
Aggregate write-ins for other revenue	122,840	
Total revenue		31,063,263
Medical and Hospital Expenses		
Physician services	18,072,810	
Outside referrals	3,864,288	
Inpatient	6,349,983	
Subtotal	28,287,081	
Less:		
Reinsurance expenses net of recoveries	1,571,759	
COB and subrogation	90,682	
Total medical and hospital		26,624,640
Administrative Expenses		4,336,956
Total expenses		30,961,596
Income/(loss)		101,667
Provision for federal income taxes		4,509
Net income/(loss)		$ 97,158

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Statement of Net Worth
As of December 31, 1998

Net worth, beginning of year	$1,060,139
Increase (decrease) in retained earnings/fund balance:	
Net income (loss)	97,158
Net worth, end of year	$1,157,297

Prevea Health Insurance Plan, Inc.
Statement of Cash Flows (Indirect Method)
As of December 31, 1998

Cash flows from operating activities		
Net income/(loss)		$ 97,158
Change in operating assets and liabilities		
(Increase)/Decrease in operating assets:		
Premium receivable		240,265
Due from affiliates		(83,273)
Aggregate write-ins for (increase)/decrease in operating assets		(842,549)
Increase/(Decrease) in operating liabilities:		
Medical claims payable		1,136,201
Due to affiliates		381,058
Unearned premiums		419,610
Aggregate write-ins for (increase)/decrease in operating liabilities		682,980
Net cash provided (used) from operating activities		2,031,450
Cash flows from investing activities		
Receipts from investments	436,201	
Net cash provided by investing activities		436,201
Cash flows from financing activities		
Net cash provided by financing activities		0
Net Increase (decrease) in cash and cash equivalents		2,467,651
Cash and cash equivalents at beginning of year		(80,769)
Cash and cash equivalents at end of year		$2,386,882

As noted earlier in the History and Plan of Operations section of this report, 1998 marked the first full year of operations for the HMO. The following schedules summarize Prevea's growth since its incorporation in 1996:

Growth of Prevea Health Insurance Plan, Inc.

Year	Assets	Liabilities	Net Worth	Premium Earned	Medical Expenses Incurred	Net Income
1998	$4,170,122	$3,012,825	$1,157,297	$30,892,822	$26,624,640	$ 97,158
1997	1,453,115	392,976	1,060,139	4,269,627	3,779,107	(399,880)
1996	1,510,414	50,395	1,460,019	0	0	(39,981)

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
1998	24,203	219.16	3.7
1997	6,927	99.03	3.5

Per Member Per Month Information

	1998	1997	Percentage Change
Premiums:	$115.40	$111.15	3.82%
Expenses:			
Physicians services	67.51	58.61	15.19
Outside referrals	14.44	13.86	4.18
Inpatient	23.72	30.61	-22.51
Reinsurance recoveries incurred	(5.87)	(4.67)	25.70
COB and subrogation	(0.34)	(0.03)	1033.33
Total medical & hospital expenses	99.46	98.38	1.10
Administrative expense	16.20	24.92	-34.99
Total expenses	$115.66	$123.30	-6.20

Reconciliation of Net Worth per Examination

The following schedule is a reconciliation of net worth between that reported by the HMO and as determined by this examination:

Net worth December 31, 1998, per annual statement			$ 1,157,297
Examination adjustments:	**Increase**	**Decrease**	
Amounts due from affiliates	$ 0	$ (240,382)	
Net increase or (decrease)	$ 0	$ (240,382)	(240,382)
Net worth December 31, 1998, per examination			$ 916,915

The above adjustment is further discussed in the section of this report captioned “Summary of Current Examination Results.”

The examination of the HMO did not result in any reclassifications of account balances.

VII. SUMMARY OF EXAMINATION RESULTS

Summary of Current Examination Results

Articles and By-laws

Review of the HMO's articles of incorporation indicated that "directors shall serve on the corporation's board of directors for staggered terms of three years, with each such term to commence May 1 of the calendar year of such director's election and to end on April 30 of the final calendar year of such term." Initially, directors were to be divided into three categories consisting of one class B and two class A directors, with terms expiring on April 30 of 1997, 1998, and 1999, respectively. The HMO is not currently following this procedure. Discussion with HMO staff indicated they became aware of this discrepancy in September 1999 and plan to take action to correct the definition of current board members' terms at the annual shareholder meeting scheduled for April 2000. It is recommended that the HMO comply with its articles of incorporation concerning the terms for members of its board of directors.

The HMO's by-laws provide that an annual meeting of the shareholders shall be held between March 31 and April 30 of each year, at such time and place as fixed by the board of directors. Prevea was unable to provide any documentation of annual meetings having been held in the last three years. It is recommended that the HMO hold meetings of its shareholders on an annual basis, as required by its by-laws.

Management and Control

In accordance with a directive of the Commissioner of Insurance, each company is required to establish a procedure for the disclosure to its board of directors of any material interest or affiliation on the part of its officers, directors, or key employes which conflicts, or is likely to conflict, with the official duties of such person. A part of this procedure is the annual completion of a conflict of interest questionnaire by the appropriate persons. The HMO has not adopted such a procedure for disclosing potential conflicts of interest as pertains to its key officers and staff members. Conflict of interest questionnaires were reviewed for the period under examination for the directors, and it appeared that potential conflicts of interest were adequately disclosed. However, it was noted that while statements existed for each year since 1996, all had been signed in August or September 1999. It is recommended that the HMO establish a procedure so that conflict of interest statements are completed each year by

directors, officers, and key staff members, in accordance with the directive of the Commissioner of Insurance.

Biographical sketches of an insurer's directors and officers are required to be filed with the Commissioner's office within 15 days of the election or appointment of such, under s. Ins 6.52 (5), Wis. Adm. Code. Examination review indicated that biographical information was not on file for three current directors and one officer. It is recommended that the HMO submit biographical information on newly elected officers and directors in a timely fashion, as required by s. Ins 6.52 (5), Wis. Adm. Code. Subsequent to examination fieldwork, the HMO did submit biographical information for these individuals and Prevea's newly appointed president/CEO. It was noted that the new CEO was appointed by the board at the end of September, but the biographical sketch was not received by OCI until November 2, exceeding the required 15-day time frame.

As discussed earlier in this report, EIW provides staff and services to Prevea under an administrative services agreement. Examination review indicated that the agreement was most recently amended effective January 1, 1998. The amendment, signed in December 1998 altered a number of sections of the agreement and its exhibits. While some of the changes were minor, others were more significant, as modifications were made to the fee mechanism of the agreement. Pursuant to s. 611.67 (3), Wis. Stat., HMOs are required to file management contracts with the commissioner. In addition, one of the HMO's chief provider agreements is with PHSI. Examination review indicated that the original agreement dating from 1996 was amended in January 1999. Under s. Ins 3.50 (6), Wis. Adm. Code, the amendments to these agreements are considered substantial changes in business plan, which is defined to include changes in plan administration and provider agreements. It is recommended that the HMO file all material changes in its affiliated agreements with OCI, as required by s. Ins 3.50 (6), Wis. Adm. Code and s. 611.67 (3), Wis. Stat.

Claims Payable

One portion of the claims payable balance reported at December 31, 1998, pertained to a payable due to PHSI under a risk-sharing component of Prevea's provider agreement with that entity. Under the terms of the agreement in effect at year-end, the HMO is to make a report of the risk arrangement calculation within 135 days of the end of each calendar year and payments are to be made

within 30 days of providing the report. During examination fieldwork, HMO staff indicated that this balance had yet to be settled during 1999. It is recommended that the HMO timely settle affiliated balances, in accordance with the terms of its written agreements.

Agents

Examiners selected a sample of new groups written during 1998 and checked whether the business was written by listed agents. Two agents were identified who were not on the OCI list of agents for Prevea. It is recommended that the HMO accept business only from properly listed agents pursuant to s. Ins 6.57 (5), Wis. Adm. Code.

Affiliated Companies

Under ch. Ins 40, Wis. Adm. Code, an insurer that is a member of a holding company system is required to annually file a holding company registration statement (Form B) and summary of registration statement (Form C) by June 1. No documentation was available during the course of examination fieldwork evidencing that Forms B and C had ever been filed on behalf of Prevea. It is recommended that the HMO comply with the requirements of ch. Ins 40, Wis. Adm. Code.

Schedule Y of the annual statement provides information on affiliates of an insurer. Per the NAIC *Annual Statement Instructions—HMO*, Schedule Y—Part 1 is to consist of a:

> "chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and HMOs and other affiliates, identifying all insurers and HMOs as such and listing the Federal Employer's Identification Number for each. The NAIC company code and two-letter state abbreviation of the state of domicile should be included for all domestic insurers."

Schedule Y—Part 1 in Prevea's 1998 annual statement did not follow the required format of including the identification numbers and state of domicile. It was also noted that the schedule described PHSI as a joint venture among Prevea Clinic, St. Mary's Hospital and St. Vincent Hospital, when in fact, Prevea Clinic is a subsidiary of PHSI. Part 2 of the schedule is to provide a summary of the HMO's transactions with any affiliates. In the December 31, 1998, annual statement, Prevea reported its service contract and reinsurance agreements with EIW, but no information was reported pertaining to the provider services agreement with PHSI. It is recommended that the HMO properly complete Schedule Y in future statutory financial statement filings.

Amounts due from affiliates are required to be nonadmitted by s. Ins 3.50 (8m), Wis. Adm. Code. The "Special Health Maintenance Organization Annual Statement Blank Instructions for the State of Wisconsin" permit an HMO to report a current prepaid capitation not in excess of one month's capitation as an admitted asset. Prevea, in its December 31, 1998, annual statement, reported its complete amount receivable from affiliates as an admitted asset. Of the $378,997 balance reported, $138,615 is considered admissible as it pertains to claims payments that could be offset against the next month's capitation payment. An adjustment is being made to nonadmit the remaining $240,382 for purposes of this examination. It is recommended that the HMO properly nonadmit amounts due from affiliates, as required by s. Ins 3.50 (8m), Wis. Adm. Code, in future statutory financial statement filings.

Disaster Recovery Plan

The HMO's operations are performed by employes of EIW pursuant to an administrative services agreement. In addition, the HMO's operations are administered on software developed by EIW. An indemnification clause within the agreement provides Prevea protection from the negligence of EIW, unless it was under the direction or instruction of the HMO.

EIW personnel indicated that the HMO would rely on the disaster recovery/contingency planning of EIW in the event of a disaster. The administrative services agreement does not specifically address disaster recovery/contingency planning issues. In addition, a review of the board minutes did not evidence that disaster recovery/contingency plans were addressed at that level.

Disaster recovery/contingency plans are usually created and maintained by a company or one of its principal affiliates, and not a contracted service provider. Since the administrative services agreement does not explicitly address this issue, it is recommended that the board formally acknowledge and document its acceptance of EIW's disaster recovery/contingency plans.

Insolvency Provisions

Under s. Ins 3.50 (4) (e), Wis. Adm. Code, an HMO is required to either maintain compulsory surplus as required for other insurers under s. Ins 51.80, Wis. Adm. Code, or demonstrate that it meets the requirements outlined earlier in this report under the caption "Insolvency Protection for Policyholders." These provisions are generally met by an HMO's reinsurance contract, but may be met by other methods, such as a written guarantee agreement by its parent organization(s). In 1999, Prevea does not have the

insolvency provisions in place in either its reinsurance contract or another written agreement. Thus, the HMO would be subject to the higher compulsory surplus requirements. It is recommended that the HMO comply with s. Ins 3.50 (4) (e), Wis. Adm. Code.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 1998, as modified for examination adjustments is as follows:

Assets		$ 4,170,122
Less:		
Special deposit	$ 45,000	
Liabilities	3,012,825	
Examination adjustments	240,382	
		3,298,207
Total		871,915
Net premium earned	30,892,822	
Compulsory factor	3%	
Compulsory surplus		
		926,785
Compulsory excess (deficiency)		($ 54,870)

(Subsequently, in July 1999, the HMO received $375,000 of additional paid-in surplus.)

As noted earlier in this report, during 1999 the HMO decided to drop insolvency clauses from its reinsurance contract. This would increase the HMO's surplus requirements to those of indemnity insurers. The company is working with its reinsurer to obtain the insolvency coverage required by regulation.

The company fails to meet the minimum financial requirements to do business in the state of Wisconsin. Compulsory surplus is not intended to be considered as the optimum level of surplus a company should have; rather it is the amount of surplus an insurer needs in order not to be in financially hazardous condition. The company is taking action to repair the surplus deficiency through capital contributions and by complying with the insolvency requirements of s. Ins 3.50 (4)(e), Wis. Adm. Code. This included consideration for anticipated future losses as well as a cushion for unanticipated losses.

VIII. CONCLUSION

Prevea Health Insurance Plan is a for-profit, group model HMO, with operations focused in the Green Bay area. The HMO was licensed on November 29, 1996, and completed its first full year of operations in 1998.

Prevea is part of a holding company group, being two-thirds owned by Prevea Health Services, Inc., and one-third by Wausau Service Corporation. The HMO contracts with EMPLOYERS INSURANCE OF WAUSAU for administrative services.

The examination resulted in one adjustment to surplus, pertaining to nonadmitting affiliated receivable balances. In addition, the examination identified a number of areas that must be addressed by the HMO. These recommendations are summarized on the next page.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 22 – Articles and By-Laws—It is recommended that the HMO comply with its articles of incorporation concerning the terms for members of its board of directors.

2. Page 22 – Articles and By-Laws—It is recommended that the HMO hold meetings of its shareholders on an annual basis, as required by its by-laws.

3. Page 22 – Management and Control—It is recommended that the HMO establish a procedure so that conflict of interest statements are completed each year by directors, officers, and key staff members, in accordance with the directive of the Commissioner of Insurance.

4. Page 23 – Management and Control—It is recommended that the HMO submit biographical information on newly elected officers and directors in a timely fashion, as required by s. Ins 6.52 (5), Wis. Adm. Code.

5. Page 23 – Management and Control—It is recommended that the HMO file all material changes in its affiliated agreements with OCI, as required by s. Ins 3.50 (6), Wis. Adm. Code and s. 611.67 (3), Wis. Stat.

6. Page 24 – Claims Payable—It is recommended that the HMO timely settle affiliated balances, in accordance with the terms of its written agreements.

7. Page 24 – Agents—It is recommended that the HMO accept business only from properly listed agents pursuant to s. Ins 6.57 (5), Wis. Adm. Code.

8. Page 24 – Affiliated Companies—It is recommended that the HMO comply with the requirements of ch. Ins 40, Wis. Adm. Code.

9. Page 24 – Affiliated Companies—It is recommended that the HMO properly complete Schedule Y in future statutory financial statement filings.

10. Page 25 – Affiliated Companies—It is recommended that the HMO properly nonadmit amounts due from affiliates, as required by s. Ins 3.50 (8m), Wis. Adm. Code, in future statutory financial statement filings.

11. Page 25 – Disaster Recovery Plan—it is recommended that the board formally acknowledge and document its acceptance of EIW's disaster recovery/contingency plans.

12. Page 26 – Insolvency Provisions—It is recommended that the HMO comply with s. Ins 3.50 (4) (e), Wis. Adm. Code.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employes of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination:

Name	Title
Danielle C. Rogacki	Insurance Examiner
Randy Milquet	Insurance Examiner—Advanced

Respectfully submitted,

Amy M. Johnson
Examiner-in-Charge